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QUERSANT ON SURGICAL DISEASES OF INFANTS, ETC.,

8 PAGES.

CLINICS.

CLINICAL LECTURES.

Clinical Lectures on Strangulated Hernia. Delivered at St. Bartholomew's Hospital, by Sir JAMES PAGET, Bart., F.R.C.S., Consulting Surgeon to the Hospital.

LECTURE I.—I propose to give you some lectures on Strangulated Hernia, a subject of great interest in practice, and one which you should do your best to learn while here; for it is only in a large hospital that you can see many cases of hernia, and only by the study of many cases that you can prepare yourselves for the great variety with which you may have to deal.

While I was on active duty at the hospital, I operated (in the hospital and in

private practice together) on about a hundred cases of strangulated hernia, and I kept full notes of nearly all these as well as of some in which my colleagues operated. It is from these notes, and from the memoranda of several clinical lectures, that I shall draw materials for my present scheme.

It may seem to you that a hundred cases of strangulated hernia should be sufficient for some statistical deductions; but they are not nearly enough. The varieties of hernia, their complications, and the different conditions of people in whom they occur, make so great a variety of cases, that it would need a tabulation of at least a thousand cases to obtain conclusions of real value. I shall, therefore, use my notes and recollections only to

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enable me to tell you what appear to be truths on some of the most important practical parts of the subject.

Our first subject may be the grounds for determining whether strangulated hernia, or one supposed to be so, is to be submitted to operation. Speaking generally, one may say, that, when in a case of hernia signs of strangulation are present, and reduction by the ordinary means cannot be accomplished, the operation for reduction should be at once performed. But then, what are the sufficient signs of strangulation? and what are the ordinary, or, better, the reasonable means for reduction without operation?

In all well-marked average cases, that is, in such as are neither slight nor very severe, neither (as some divide them) acute nor chronic, these following may be regarded as the signs of strangulation justifying operation. The hernia, usually reducible, or now first formed, cannot be reduced by reasonable means. If not recently formed, it is larger than usual, tense, firm, or even hard; without impulse, without resonance, painful, and tender on pressure, especially at its mouth and neck. The bowels do not act, though they may often be felt contracting, and may cause much colic and spasmodic pain, especially at the navel and the pit of the stomach. With this pain there is commonly some tenderness, with a feeling of tightness in the abdomen, especially about the navel and between it and the seat of the hernia. The patient is often sick, vomiting nearly all the food and drink that he swallows, and, besides, a quantity of gastric and biliary secretion, or of the contents of the small intestines more or less diluted. The pulse and respiration are usually quickened and rather feeble; the patient feels and looks restless, low, and miserable—or, as it is called, “anxious.” He cannot sleep or eat; and the hands and feet are apt to become cold and shrunken and dusky.

Whenever all these things are observed, and when they remain after such reasonable attempts at reduction without operation as I will presently speak of, you may hold that the operation should be done without delay. Much more, if possible, should it

be done if these things be all worse than I have described. When the integuments over the hernia are inflamed, thick, swollen, and ruddy, or emphysematous; when the whole abdomen is swollen, tense, and tender; when the vomit is just like the liquid feces of the ileum; the pulse very rapid, feeble, and small; the skin cold and dusky and clammy; when the patient is dim in sense and mind, or in an anguish of misery with retching and hiccough; where all or the greater part of these elements of what the old writers called *miserere* are combined; then, without trying any other method of reduction, you must instantly operate, though you may have only the slenderest hope of doing good, and a serious fear of seeming to do harm.

Thus far, one may speak very positively. In the cases which I have sketched, there are sufficient signs of strangulation; and if the hernia cannot be safely reduced without operation, the operation must be done. But you will not see many cases without seeing some in which, although the hernia may be irreducible, yet the signs of strangulation are very slight, obscure, incomplete, or in some other way not sufficient to make it nearly certain that the operation is necessary. It is an easy rule for all these cases that, whenever you suspect that hernia is strangulated, you should operate. If you will follow this easy rule, you will do some very bad surgery; you will kill a few patients whose lives you ought to save; and you will make many ill for two or more weeks who might be well in as many days or hours. You must avoid the easy rule, and learn the hard one of discriminating the cases that require operation. You must learn to discriminate those on which the operation must be done at once, without any previous attempts at reduction, and those in which before operation one or more attempts at reduction should be made with chloroform or other helps. For the purpose of such discrimination, let it be your design, in each case of strangulated hernia, not to choose any measure for its reduction till you have fully weighed the signs of strangulation of which I have spoken. For convenience of thinking, you may divide them into

the local symptoms, including all the characters of the hernia itself, and the less or more remote or general symptoms, especially the inactive bowels, the state of the abdomen, the vomiting, the pulse and respiration, and the general condition. I will try to tell how each of these, in its several degrees, may be estimated.

1. First, of the local symptoms, the irreducibility of the hernia, its unusual size, its tension or hardness, and the others which I enumerated, a few rules may include all that I can tell of these. It will be convenient to speak of irreducibility last; for, though it may seem as if it should be the condition decisive for operation, it is really a fallacious sign of strangulation; and, in some instances, no trial should be made to test its existence. As for the other local symptoms, their presence, even in a marked degree, is not decisive of strangulation, and is not sufficient to prove the need of operating when the remoter signs are not present. For the local symptoms may be found when a hernia, or its sac, is acutely inflamed, though not strangulated. In this state, which may follow injury, or even arise spontaneously, a hernia may become quickly larger than ever, firm and very tense, without impulse, very painful and tender, hot and red, and not at all reducible by any fair means. The sac may suppurate, the integuments may slough; and yet there may be no strangulation and no need of an operation. I have, indeed, only once seen this sloughing of the integuments over a hernia; but the case is not likely to be without parallel, and was a glaring instance of the fallacy of the local signs of strangulation.

A very stout elderly lady had a large umbilical hernia, which became painful, tender, and irreducible; her bowels did not act, and she felt sick, but did not vomit. There appeared no urgent need for an operation, and she was one in whom an operation was not to be undertaken lightly. But, after three days' watching, during which the local, but not the remoter, signs had somewhat increased in severity, I found that a large portion of the thin integuments covering the hernia had rapidly sloughed. I ope-

rated at once, though with little hope of doing good; for I supposed that the contents of the sac must also have at least partially perished; but they were not even severely strangulated; the mouth of the sac was too small for their return, but they were not tightly girt, and the intestine was only moderately congested. The sloughing of the integuments seemed due to inflammation in a very feeble person, and an ill-nourished part; and with the same feebleness the patient died on the day after the operation.

You may find, then, and not rarely, that the local characters usually present in a strangulated hernia may be imitated in an inflamed hernia which is not strangulated. And, though very rarely, many of the remoter signs—the constipation and the vomiting, the quickened pulse and breathing, and the rest—may exist when a hernia is inflamed but not strangulated. How, then, can you discriminate? Generally thus: in the inflamed hernia, without strangulation, the local signs precede, and greatly predominate over, the remoter and general signs; while, in a hernia which is inflamed after becoming strangulated, the remoter and general signs will still predominate over the local, and the history will tell that they preceded.

These means of discrimination, however, will not always suffice. You will meet with cases in which you will be uncertain whether the hernia be only inflamed and irreducible, or strangulated and inflamed; but in these cases you must not be uncertain of your practice. If you cannot very easily reduce the hernia, you must operate. The risk of operating on a hernia which is inflamed and not easily reducible is very small, in comparison with the risk of leaving one which is inflamed and strangulated; and even if you find reasons for waiting, it must be with the most constant oversight, for an inflamed and irreducible hernia may at any time become strangulated, and will certainly do so if not relieved by rest and other appropriate treatment.

For a second rule: if the remote signs of strangulation be present, the local signs are urgent for speedy operation in the same degree in which they are marked, or

in even a greater degree; for severe strangulation is often associated with slight local symptoms.

But, to judge rightly from the local symptoms, each may need to be carefully weighed as evidence for the necessity of operating, or of adopting other methods of reduction.

In reference, then, to the chance of reducing a hernia without operation, it is a bad omen when one has quickly come down much larger than ever before. A great majority of patients give this as the beginning of their troubles. Sometimes they tell that, while making a great effort, they felt the descent come larger than ever; that they felt some pain or more than usual increase in the hernia, and could not reduce it in the customary way. More often the larger descent has happened without apparent cause. While the patient was sitting, or in bed, or quietly walking, the descent has occurred; but, perhaps, most frequently it has seemed connected with some diarrhoea, or colic, or spasmodic pain, or with some kind of turbulent movement of the intestines, for some hours, or a day or two, before the descent. In some cases, moreover, the unusual size of the hernia is attained at once; in others by gradual increase. In some it very quickly becomes painful; and these are rather less likely to be reduced than those in which pain follows more slowly.

I cannot give you any satisfactory explanation of these unusual descents of hernia or of their becoming strangulated; but let them teach you not to be deceived by any notion, that some unusual or startling event is necessary as a cause for the strangulation of an old hernia. And I believe it may be held as a safe rule in practice, that the more a recently-descended hernia exceeds its usual size, the less is the probability of its being reduced without operation; and I think that the probability becomes the less, the more the size of the hernia continues slowly to increase; for not a few of those that have suddenly become very large, and then have not increased, may be reduced without operation, if the patient be put under chloroform soon after the descent.

Similarly, when general signs of strangulation exist, the harder and more tense a hernia is, the less is the chance of reduction without operation. The hardness may be due to any one of several conditions, but, to whatever it may be due, it is an untoward sign. It is especially so, if the hernia be a small one. In large herniae, the hardness may chiefly be felt at and near the neck and mouth of the sac, especially in inguinal herniae; and you must take care not to be deceived by a sac which is soft and flaccid everywhere except at its mouth; for there may be strangulated intestine in the mouth of the sac, though the rest contain only soft omentum or fluid not sufficient to distend it. Nay, you must not let even a wholly soft condition of the hernia, or an open external ring, weigh down against the well-marked general signs of strangulation; for the piece of intestine at the mouth of the sac may be too small to give a sensation of hardness, or the whole hernia may be omental.

Again, if the general signs of strangulation exist, the more painful and tender a hernia is, the less, speaking generally, is the chance of reduction without operation. But here it is to be observed, that this rule holds less for recent than for old herniae. A recent hernia may be horribly painful, apparently because of the tension of the stretched fibrous tissues about the sac's mouth. Yet such an one may commonly be reduced with the help of chloroform; but an equally painful old hernia, or one that has slowly become thus painful, may require speedy operation. And the operation must be all the more certainly done when, together with any of the remoter signs, there are other local signs, such as inflammation of the coverings of the sac, suppuration, emphysema, or the like. These are imperative for operation, without any previous attempt at reduction.

And for another rule: if the remote signs of strangulation be well marked, and the hernia cannot be otherwise reduced, you must operate, though there be no marked local sign at all. Or, even beyond this, if the general signs of a strangulated hernia be present—the constipation, vom-

iting, and others—and there be anywhere a swelling which may be a hernia, though it seem not likely to be a strangulated hernia, the operation must be performed at the seat of that swelling.

Reasons enough for this rule may be found in the many cases in which the local signs of a strangulated hernia are so little marked that the patient, having his attention spent on the misery of his vomiting and epigastric pain, and other symptoms remote from the hernia, says nothing of the hernia itself. In not a few of my recorded cases, the hernia had been overlooked for a day or more; and the patient had been treated for spasms, colic, dyspepsia, or some other imitated disease, while the hernia was obscurely becoming hopelessly strangulated.

This last rule of operating, though there be no local signs of strangulation, may lead you into trouble; into the trouble and discredit of performing an useless operation, and seeming to do much more harm than good. But this you must face; it is just in instances such as this that surgery must incur the risk of seeming to do harm rather than miss the opportunity of doing good. I have operated thus uselessly in three cases. One was an irreducible umbilical hernia, in which there was no strangulation; but vomiting and other signs of strangulation, caused by (I believe) gallstones. Another was a simple femoral hernia, with an internal strangulation of a piece of intestine far away from it. The third was an inguinal hernia with the same complication. All the patients died, and my operations seemed worse than useless failures. But you must face this risk of seeming wrong.

You may have to go further than in these cases; and, if, for instance, a patient have two hernia that are irreducible, and signs of strangulation, and you cannot tell which is strangulated, you must operate on both. I saw Mr. Stanley do this; and no one could blame him, though, when death followed, it was found due to an internal strangulation distinct from both the hernia.

These are the chief rules, so far as I have been able to learn, according to which you may use the local symptoms of a supposed strangulated hernia as a part of the

evidence for determining for or against an operation for reduction. And to these it may be briefly added that the local symptoms are generally less severe in the old than in the young; in old hernia than in new; in omental hernia than in intestinal.

2. Let me now go on to speak of the guidance to be derived from the remoter symptoms; and, first, from the inaction of the bowels. This inaction, or rather this hindrance to expulsion, is a nearly constant sign in strangulated hernia, but it occurs in so many other cases that its sole presence is of little weight among motives for operating. Its absence is, rather, that which needs study.

One or more actions of the bowels, after other signs of strangulation have set in, are of no weight at all against the propriety of operating. They commonly occur, because usually after strangulation the part of the bowel below the constricted part empties itself. These actions of the bowels are not to be counted on either side of the question about reducibility or operation; and even a regular and frequent action is not an absolute prohibition, for the strangulation may involve only omentum, or only a part of the circumference of a portion of intestine. In these conditions, feces may pass along the canal and be discharged.

I had to see a lady for what was considered an abscess in the groin. The swelling was just over the femoral ring, and contained fluid and air. I punctured it, and let out pus and air and liquid feces, and presently I found a piece of hernial sac sloughed off and lying in the abscess. This, and the history of the case, proved that the hernia had, about a week previously, descended when the patient felt a sudden pain while driving. The hernia was so small that it was overlooked; its pain and the griping which it caused were thought due to colic, and were so treated. The bowels acted sufficiently, and gradually the little hernial sac and its inclosed piece of the intestinal wall died and sloughed off. Then came the signs of abscess over the femoral ring, and its outlet; and this was followed by complete healing and many years of health.

However, such cases as these are very

rare; and you may hold by the general rule, that you should not operate when the bowels act frequently or regularly, unless all the other signs of strangulation, both local and remote, be well marked.

3. The state of the abdomen is as little or less decisive in cases in which you may be in doubt. Of course, if it be sensitive and tender on pressure, either everywhere or in parts near the hernia, still more if it be distended and the muscles hard, this is an addition to the reasons for operating, and, I may add, to the reasons for fearing that you may be too late. It is more to be remembered that, when the abdomen is not tense or tender, when it may even feel nearly natural, yet you must operate if other signs of strangulation be present, and the hernia cannot be put back. For the changes of the abdomen are not common near the beginning of strangulation, and to wait for them would often be to wait till too late.

4. If I were asked which of the signs of strangulation I would most rely on as commanding the operation, I should certainly say the vomiting. Time after time, when the other signs were feebly, if at all, marked, the vomiting has been a sufficient guide to a timely operation. Many times, when all else was so quiet that it seemed rash to operate, the vomiting proved that it would have been much more rash to wait; and not one instance can I find in my notes in which neglect of the import of vomiting was not proved to be unwise. You had better hold the rule complete, that, when a patient has a hernia, recently become irreducible, and, with this, vomiting which cannot be clearly assigned to something independent of the hernia, you should operate. I am obliged to say recently become irreducible, because a patient with an old irreducible hernia may vomit, as any one else may, without any reason for suspecting strangulation; though in even these old cases you must be very watchful lest the vomiting may be an early stage of strangulation. But the rule is safe that recent irreducibility and vomiting are enough to justify the operation, even though there be no other sign of strangulation present. Much more must the operation be deemed

necessary when with these the other signs of strangulation, in even slight degrees, coincide.

And in this judging of the vomiting, do not be too scrupulous as to its manner or its products. There are indeed some notable modes of vomiting when intestine is strangulated. The patient vomits all he drinks, and that soon after taking it; and besides, he vomits fluids of his own secreting; and this vomiting is commonly (at least in the later stages), with gushes of large quantities of fluid, without much retching or violence, as if the stomach slowly became full of its own secretions and those of the upper part of the intestine, and then, without any preceding nausea, suddenly emptied itself.

When you see these kinds of vomiting with a hernia lately become irreducible, or even with any swelling that may be a hernia, you may be sure that you must operate. But do not wait for any supposed characteristic mode of vomiting; do not be misguided by the absence of some peculiar fluid; nay, do not be misguided by the absence of all vomiting; for I have known it absent in the case of a very large hernia, which was certainly strangulated, and on which I operated successfully; and do not be misguided by an apparent diminution in the severity or in the frequency of vomiting, or by the vomiting having begun as soon as the hernia descended; for this it often does. Any kind of vomiting, if it be repeated, is enough to justify operation in a hernia recently become irreducible. Let me tell an illustrative case, which taught me the more, because it occurred in one whose life was of great value. He was aged 56, weakly, but laborious in literature. For three days after the descent of a hernia, which could not be reduced as it usually had been, there was not a single sign of strangulation, except this irreducibility, constipation, and occasional vomiting. He had no pain in or near the hernia; no feeling or aspect of illness; no hardness or tension of the sac; and the vomiting was only occasional, and there were often many hours of interval. But, after the three days, abdominal pain suddenly set in, with coldness and faintness, and

wretchedness. Within two hours I operated; but it was too late; peritonitis had already begun, and the operation was useless or worse than useless. He died in twenty hours.

Cases like this are frequent. All seems pretty well; and then comes an inrush of indomitable symptoms. The hernia is not acutely inflamed; the patient is not greatly distressed; he flatters himself that he is better, and the similar flattery of his friends is yet stronger; all are averse from operation, and you can hardly persuade yourself to be resolute about it. But there should be no hesitation. I lost the chance of saving this man's life, by underestimating the importance of occasional vomiting as a signal for operation. If you lose such chances, you will be still more blameworthy; for you will have had more warning than ever I had.

And once more; do not be deceived by the cessation of vomiting in the extreme condition of strangulated hernia. This sometimes happens; but it is a token of evil rather than of good, if general improvement do not coincide with the cessation of vomiting. So, again, sickness may be stopped by narcotism; but here again there is no evidence of such general improvement as might justify waiting.

5. In the recent stages of strangulation, if it be not very acute, the respiration and pulse are little affected. The pulse is usually accelerated, and at first may be full and firm. I find that it was between 80 and 90 in a large majority of the ordinary cases which I have recorded; and the respirations are, generally, I think, in due proportion to the pulse. As the other signs of strangulation become more marked, these, I think, always coincide with them. The pulse usually becomes quicker, feebler, smaller, unless indeed after the warm bath, when its strength and size may be greatly increased; the respiration, I think, keeps pace with the pulse.

Thus, these signs corroborate the others in urging to an operation. I have not any notes or knowledge of cases in which the pulse or respiration was so inconsistent with other signs of strangulation as either to justify or to forbid the operation. But

you may have this for a safe rule; that if, while you are watching a case, doubtful whether there be strangulation, the pulse and breathing should increase in frequency, you may believe that there is a commensurate increase in the reasons for operating.

Lastly, as to the patient's aspect and general condition, little that is definite can be said. You read of an anxious expression, and it is called characteristic, as many other fallacious things are. I should rather call it an expression of distress or of misery; but, however you may name it, be careful not to think that you must see it before judging that it is right to operate for a strangulated hernia. The worse a patient looks or feels; the more he looks shrunken, worn, and old-aged; the more miserable his sensations; the more is it unlikely that his strangulated hernia will be reduced without operation. But the reverse is not true. I have operated with full right, as proved by the result, on patients who neither looked nor felt miserable or anxious in any sense of the word. And I have seen a patient looking well and tranquil, in whom a femoral hernia, after seven days' strangulation, contained completely gangrenous intestine.—*British Medical Journal*, April 6 and 13, 1872.

HOSPITAL NOTES AND GLEANINGS.

Dr. Murchison's Clinic at St. Thomas's Hospital.—The interest and value to the ordinary student of cases in a medical ward are mainly dependent upon the teacher, and upon the time and trouble devoted by him to their study and exposition. How frequently one is met with the answer that there is "nothing much in the ward;" that "there are no interesting cases in at present," and such like expressions. There are perhaps occasionally seasons of dearth; but our own experience has led us to observe that "good cases," by, we presume, some unaccountable law not fully recognized, never fail to come in large and unfailing numbers under the notice and into the wards of the few clinical teachers of the London metropolitan schools. Every case of dis-

case is interesting and instructive, provided the physician or surgeon take the trouble, and possess the knowledge and genius to make it so. We have never failed to find a practical application of these remarks in attending the visit of Dr. Murchison. Indeed, so far as clinical material is concerned, there is at present almost an *embarras de richesses* in his wards.

Embolic Hemiplegia, with Chorea Movements.—In some cases of chorea, embolism of certain cerebral vessels has been observed after death. The interest of the present case was accordingly enhanced, as the appearance of chorea bears on the pathology of the affection. The patient was a boy, aged 8, who had passed through an attack of acute rheumatism, with mitral valvular disease, and who, six months afterwards, became the subject of incomplete and apparently embolic hemiplegia of the left side, for which he had been admitted one month previously. It was observed at the time of admission into the hospital, that choreic twitchings, especially on the paralyzed side, were present. These, however, had now left, and the boy had almost entirely regained the use of the left side.

Well-marked and prolonged general Symptoms of Phthisis before the Appearance of Cough and Local Signs.—The patient, a man 39 years of age, had been for three months the subject of night-sweats, rigors, emaciation, and symptoms of hectic fever, and other signs of phthisis, without any of the physical signs of the chest denoting the existence of the disease, and without any cough. These, however, at length developed themselves in a well-marked manner while under observation. Such cases, Dr. Murchison observed, are occasionally met with.

Dropsey (chiefly Hepatic) relieved by the external and internal application of Digitalis.—The value of digitalis as an external application has been long recognized, although acted upon in a very limited degree. In the present case, the patient, a boy, aged 11, had been an invalid for twelve months. His illness commenced with an attack of acute rheumatism, which left him with a double mitral murmur,

He was admitted into the hospital in November, when his legs were found to be edematous, and his urine albuminous. The edema diminished under acupuncture and other treatment, and the albumen, after a recurrence, entirely left; at the same time, evidences of ascites supervened, which Dr. Murchison believed to result from a fibroid condition of the liver, which had also in the mean time increased in size, consequent on the long continued cardiac congestion. Paracentesis abdominis was had recourse to for temporary relief after the abdomen had been greatly distended. The fluid again began to accumulate. The patient was treated by tincture of digitalis and iron internally, but without any effect upon the ascites. Digitalis was, however, in addition applied externally, in the form of infusion made four times the pharmacoposial strength, to the loins and abdomen, and with marked effect, the flow of urine increasing, and the ascites diminishing considerably.

Empyema; Rupture into Bronchus; Convalescence.—The subject of the affection was a man, aged about 40, the history of whose illness was an urgent attack of pleuritis in the right side, which was followed for eight weeks by the pain of distension, and subsequently the sudden expectoration of an enormous quantity of pus. He was admitted into the hospital four months after this occurrence, when it was found that the measurement of the affected side was less by an inch and a half than the healthy one, and that some symptoms of fluid still remained in the right pleural cavity. Dr. Murchison pointed out that, in this case, the general indication in the treatment had been to improve the general health of the patient. This had been followed out, and now, after a residence in the hospital of about six weeks, there were evidences of increasing recovery of the lung, and the patient had gained in weight.

Violent Diarrhoea and Vomiting from eating Pork.—In this case, the symptoms, which were rather violent, were clearly traceable to the patient's dining on pork. Dr. Murchison pointed out that cases were not unusual, in which an article of

diet which proved harmless over and over again, would produce in the same person severe gastric symptoms. Such was the case in the present patient.

Obstinate Attack of General Dropsy, with Edema of the Lungs.—The patient, a wretched-looking and dwarfed boy, aged 11, was suddenly seized, ten days before admission, with general dropsy, ascites, oedema of both lungs, and cough. No cardiac or renal mischief was discovered; and, although the liver was slightly enlarged, still there was not sufficient mischief in that organ to account for the dropsy. The spleen was large, but there was no increase of temperature. Dr. Murdoch, in the absence of any apparent organic disease, was inclined to believe that the condition of the patient was due to some morbid condition of the blood. He was improving on iron.

Syphilitic and Amyloid Disease of the Liver.—The subject of the disease was a man, rather intemperate, aged 45, who, when admitted, presented symptoms of ascites, enlargement of liver, extensive cicatrices of the tongue, and cicatrices of previous ulcers on the legs; the spleen was also much enlarged, but the urine contained no albumen. The ascites diminished under treatment, and the liver was then found to be enlarged. He was now being treated by nitromuriatic acid and gentian.

Good Effects of Aconite in acute Pneumonia.—Amongst other cases of interest which came under our observation in the male wards, was that of a boy aged 15, who was admitted with acute pleuropneumonia of the right side and herpes labialis, and considerable increase of temperature. On the administration of eight-minim doses of tincture of aconite, with liquor ammoniae acetatis every four hours, the temperature at once came down, and the disease did not increase.

A case of spinal meningitis recovering under treatment by belladonna and iodide of potassium; one of granular kidney in a painter, with hypertrophy of the left ventricle and chronic changes in the retina; and a case of double pneumonia, with extension of the inflammatory process to the pericardium, also presented some

points of clinical interest.—*Brit. Med. Journ.*, July 18, 1872.

Obstinate Constipation, probably dependent on Chronic Lead-poisoning.—The patient, a woman aged 40, was admitted with colic and constipation of ten days' standing. She complained of great pain in the abdomen, which was mostly paroxysmal, but from which she was never entirely free. There was very little tenderness of the abdomen, and no fever, but there were occasional sickness and vomiting. There was a distinct blue line on the margin of the gums, and this symptom assisted in arriving at the diagnosis of simple constipation, although it was impossible to trace the manner in which the lead had been introduced into the system. Small enemas of oil of laudanum, followed by large injections of gruel, were administered, with good results. One or two spontaneous motions were afterwards passed, and she seemed to be doing well. Latterly, however, she appeared to be again getting into the same state, and for five days her bowels had not been opened. She was now ordered enemas of assafetida. To relieve the abdominal pain, she was at first ordered pills of belladonna and opium, with satisfactory results.

Intermittent Sarcinous Vomiting with Organic Disease of the Stomach.—The subject of this affection was a woman aged 49, who had been suffering for six months from vomiting of sarcines, and other symptoms pointing to malignant disease of the stomach. The vomiting came on at intervals of about seven days, and was very copious. All the gastric symptoms, including the vomiting, were relieved by creosote and morphia, in the proportion of one minim of the former to doses of the latter increased to half a grain.

Circumscribed Empyema pressing down the Liver: Paracentesis.—The patient, a female, about eight years of age, had fallen six weeks before admission. This was followed by pain in her right side. When admitted, she presented all the signs of pleuritic effusion in the lower part of the side. The lower margin of the liver descended below the umbilicus, and there

was displacement of the heart towards the left. The measurement of the right side increased greatly, without the dulness extending higher. At last fluctuation was detected at the most prominent part *below* the ribs. This was tapped below the ribs four weeks ago, and fifty-four ounces of pus were drawn off, greatly to the relief of the patient. The liver now ascended, but the level of the upper margin of dulness remained unchanged. The fluid, however, began to reaccumulate, and her temperature once more arose, and she presented symptoms of constitutional disturbance. A counter opening was now made in the back, when eight or ten ounces of fetid pus passed out. A drainage-tube was introduced and the pleural cavity was washed out daily with an aqueous solution of carbolic acid, in the proportion of one per cent. of the acid. Her progress had since been satisfactory; her general health and the local conditions had improved; and the temperature was now normal.—*Brit. Med. Journ.*, July 20, 1872.

Cases in Dr. Peacock's Wards in St. Thomas's Hospital, and Clinical Remarks.—*Pleurisy.*—When we visited Dr. Peacock's wards lately, there had been a "run" of cases of pneumonia and pleurisy, acute and chronic, simple and tubercular—forming together a very interesting group. One woman had been admitted with one side of the chest so full of fluid that the advisability of paracentesis was mooted; however, a diuretic and tonic plan of treatment with counter-irritation to the chest had effected the absorption of the fluid, and the patient was convalescent. Dr. Peacock observed that pleurisy was generally described in books as a disease attended with active inflammatory symptoms; but in many cases the patient was scarcely aware of anything being wrong till one side of the chest was more or less full of fluid; there was generally some discomfort, but often little pain and little fever, little more indeed than great prostration of strength and some shortness of breath. The disease progressed insidiously until the patient began to suffer from dyspnoea, etc., due to the effusion.

Pains in the chest were common enough, but were often due to other causes, as pleurodynia; still they must never be neglected. Simple pleurodynia occasionally passed into pleurisy. He had been annoyed more than once by hearing unmistakable friction after listening vainly on several days, and after having given an opinion that the pain was merely rheumatic. The study of text-books, again, would lead to the idea that there was but one sort of pleural friction; that usually described is the "sound of ascent and descent" of Laennec—a harsh, sonorous friction-sound, due probably to the rubbing together of the dry surfaces of the pleura. This is very characteristic, but is by no means the only, nor even the most common, form of friction sound; and, when it occurs, it has often disappeared before the patient is removed into hospital. Perhaps the most common form is what might be called "subcrepitant friction," a somewhat fine crackling sound, which differs from the subcrepitant chiefly in being very superficial. This form of friction is very commonly heard during the process of absorption of a pleuritic effusion; it is probably due to the rubbing together of the surfaces of membrane when covered by thick soft layers of lymph. In many cases, too, this is not constant; it disappears after a few deep respirations, to reappear in the same place after an interval. In many of the insidious cases just referred to, friction is absent throughout; there is a large effusion of fluid with only a little lymph, and when the fluid is absorbed, the pleura retains its healthy condition.

Encysted Pleurisy.—Another very interesting case was that of a blacksmith, a tall, well-made man, aged 27, who, on admission, had absolute dulness with complete absence of breath-sound over the upper third of the left lung, and much fulness in that situation. Six months before admission, he had some haemoptysis, and a little before that had suffered from slight cough and some failure of health; on the other hand, his aspect was not tubercular, and his family history was good. The physical signs were so marked as to give rise to a suspicion of malignant

growth, but there was no acute pain, swelling of the arm, or other sign of the pressure of a tumour. Dr. Peacock diagnosed encysted pleurisy, and, with the aid of blisters and tonics, the fluid was absorbed; some amount of consolidation, apparently tubercular, was left.

Empyema.—There were two cases of empyema, in both of which the fluid had been evacuated by the lungs. In one, a girl, about twenty-four years of age, the pus had also discharged itself externally, but the opening had healed quite soundly, the side was gradually contracting, the respiratory sounds were returning, and the young woman had improved greatly in health. The other was a boy, aged 10, who had been sent into the hospital for supposed pneumonia. Shortly afterwards, he suddenly expectorated, after a severe fit of coughing, a large quantity of pus; a considerable part of the previously dull area of his chest was now found to be somewhat tympanic, and when he coughed there was a loud amphoric sound. Since then he had continued to expectorate pus at intervals, but the side was gradually contracting, the lung expanding, and the amount of fluid in the cavity was diminishing. Although pale, the patient was stout and lively; indeed, the trouble throughout had been to keep him quiet in bed.

Dr. Peacock remarked that, in cases of phthisis, the symptoms of perforation of the lung are often much less severe than one would expect. When it occurs in a case of early phthisis, whilst the patient is still in fair health, the symptoms are sufficiently well marked; but, in any more advanced cases of the disease, pneumothorax may supervene, with so little local pain and additional constitutional disturbance that its occurrence may be overlooked. In some cases, too, the escape of air and consequent effusion of fluid is limited by adhesions, rendering the physical signs very anomalous and puzzling. A sign which is always mentioned in books, and often the first which is given by a student under examination, is the peculiar sound produced by succussion; this is, however, a very uncertain sign, only met with when there is a considera-

ble amount both of air and fluid in the pleural cavity, and when this cavity is tolerably free from adhesions. Dr. Peacock added that, although the prognosis of such cases as these is not very favourable in adults—permanent fistulae being often the result—children generally do well. He has witnessed so many spontaneous cures that he does not, as a rule, advise an operation; if, however, the patient be distressed or greatly inconvenienced by the amount of the effusion, or if he cannot readily expectorate the matter, he would at once perform paracentesis; he prefers that the opening should be free and that the patient should wear a canula, or better still, that a counter-opening should be made and a drainage-tube inserted.

Speaking of *Pneumonia*, Dr. Peacock said that his experience of the disease as seen in London did not agree with what was generally stated, as to the rapid recovery of the patients and the complete disappearance of the physical signs in a short time. A sudden fall of temperature, indeed, does generally occur; but he finds that the physical signs usually clear off very gradually, and that evidence of a certain amount of damage to the lung often persists for a considerable time. The rapidity of the recovery depends also very much on the simple or complicated character of the case; after pleuro-pneumonia and broncho-pneumonia, convalescence is often very protracted.—*Brit. Med. Journ.*, July 20, 1872.

Intracranial Tumours.—At a recent visit to the London Hospital we saw, under the care of Dr. HUGHINGS JACKSON, several cases of intracranial tumour, or rather cases in which that diagnosis had been confidently made. One was that of a boy nearly nine years of age, who was supposed to have a tumour of the middle lobe of the cerebellum. A case very like it, in the life history, and in which tumour of this part was found, is recorded by Dr. Hughlings Jackson in this *Journal*, November 4th, 1871, page 528. In both cases, there was, at the beginning, irregular gait; there were double optic neuritis and enlargement of the head. The pa-

tient we saw at our recent visit is in an advanced stage, he lies on his back with his legs and feet extended, and with his arms flexed acutely at the elbows. There is, however, no drawing back of the head; there is no arching of the back; and his abdomen, although sunken, is not at all hard. The head is almost constantly turned to the left, as are also the two eyes. From this position he never moves, except that the eyes occasionally wander to the right. His head is not only large—strikingly above the ears—but it is evenly enlarged, for the sagittal suture gapes widely (no relics of rickets in his body). A tumour of the middle lobe, by pressure on the veins of Galen, will cause hydrocephalus. Mr. Hilton thinks that the cause of the common form of hydrocephalus is the result of closure of the cerebro-spinal aperture, which, according to him, is usually open. Possibly, then, in this case, the tumour closes this opening. But, whatever the mechanism may be, we see that, in an indirect manner, disease of the cerebellum can affect the cerebrum; there are mental symptoms in these cases. In a case closely like this in Guy's Hospital, many years ago, Sir Wm. Gull drew attention to the very general fading out of mind (a tumour of the middle lobe of the cerebellum was found, *post mortem*, as Sir Wm. Gull had predicted). In the boy whom we saw, there is great apathy; he never speaks unless he be spoken to, when he replies correctly. He lies on his back in one position all day, never taking notice of anything unless directly addressed. But against this is to be noted the fact that he can sing. Mr. Stephen Mackenzie has heard him sing several songs; songs which he had learned when well, and which he used to sing at home. He sang for the class, and apparently with great interest, the first verse of "Up in a balloon."

In these cases, the intracranial pressure will be very gradually exerted (nervous matter bears slowly exerted pressure very well) and very evenly distributed—pressure by fluid. Thus we may account for the very general mental affection—the "fading out of mind." Power to sing is no very strong evidence of mental power.

It is a largely automatic act. Aphasics can sometimes sing, and some idiots can. But it must be again remarked that the boy gives courteous and exact replies to simple questions; moreover he replies readily. In Sir Wm. Gull's case, towards the end of life, the interval before replying was so long, that a hasty observer would have supposed that the patient was deaf or entirely demented; but at length the reply came, and it was slow and monotonous. The absence of deafness in these patients is noteworthy. In cases of intracranial tumour, it is as important to note the almost constant absence of deafness as it is to note the almost constant presence of blindness (partial or total).

In the boy whom we saw, there have been no tetanus-like fits, as there were in the case recorded in November. From theoretical considerations, Dr. Hughlings Jackson has been led to suppose that the changes which cause the tetanic paroxysm and the interparoxysmal "set" of the trunk and limbs in tetanus are seated in the cerebellum, and not in the spinal cord, or not limited to it. But, since two such able observers as Lockhart Clarke and Clifford Allbutt have described changes in the cord in tetanus, he has refrained from fully stating this hypothesis. In the mean time, he diligently collects observations as to the tetanus-like affections, especially in the case where a gross (an obvious) lesion is likely to be found *post mortem*, to fix approximately the seat of the minute changes causing the paroxysm. Hence the interest of the tetanoid fits in the case related in November. In some cases of cerebellar disease there is only a fragment of the tetanus-like condition.

There is (we may now say there was, for the patient died a few days after our visit) a woman, aged 52, who was plainly the subject of intracranial tumour. The double optic neuritis, the severe headache, and urgent purposeless vomiting, warrant this diagnosis. The doubtful questions were as to the position and nature of the tumour. She mostly lay in bed during her stay in the hospital, but when induced to walk, she "walked badly." Besides being quite blind, she was so dull and also so exceedingly timid and suspicious, that it

was difficult to make a more precise statement. She could not stand by herself; and it was particularly remarked that she fell backwards when left without support. Besides this, she was quite deaf of the right ear. These were the only localizing symptoms at first. Later, there was a nasal articulation, and the head was placed slightly to the left; her voice remained good to the last. It was supposed that the tumour lay under the tentorium, on the right side, so as to compress the auditory nerve. It was found, however, in the right posterior cerebellar fossa, or rather inserted, as it were, betwixt two flaps of the right cerebellar lobe, from which position it was detached—almost fell out—on removal of the brain. Whether the deafness was the result of indirect compression of the soft auditory nerve, remains doubtful. In such a case it is not worth while to speculate as to the relation of the falling backwards to disease of the auditory nerve or the semicircular canal, as there was a large tumour of the cerebellum. It would be unwarrantable to say that disease of the cerebellum itself produced the deafness—although the cerebellum does receive a larger share of the auditory nerve—because in most cases of cerebellar disease there is no deafness. But, again, it may be urged that the deafness was the result of an auditory neuritis. But, once more, tumour of the cerebellum is very rarely attended by deafness any way caused. Nothing is rarer, says Vulpian, than trouble of hearing in alterations of the cerebellum. (Of course, cases of abscess of the cerebellum from disease of the ear have no bearing on the question.) As to the nature of the disease, there were, at first, no doubts on the important question whether it was syphilitic or not, or rather, the style of the symptoms never suggested syphilis, and inquiries elicited no information about it. But about a month before her death, a nasal tone of voice led to an examination of her throat, and there was seen what was supposed to be an ulcer, on the back of the pharynx; "supposed," as, from her condition only a flying sight of it was to be got. On the chance of its being syphilis, large doses of iodide of potassium were

given. At the necropsy, the pharynx was examined, and no trace of ulcer or cicatrix was found. The tumour was not syphilitic.

There is a woman in the Hospital aged 37, who is believed to be the subject of intracranial tumour. She has had headache, vomiting, and double optic neuritis. She was in the hospital just about a year ago; and the interest of her case is that both then, when the neuritis was in an acute or severe stage, and now she can read No. 2 of Snellen, although the changes in her discs have not even yet completely disappeared. It is, Dr. Hughlings Jackson says, extremely common for severe optic neuritis to exist when the patient can read the smallest type, and, what is more important, in some cases the changes pass away almost entirely—so far that a careful examination by the direct method is necessary to detect any abnormalities—when sight has never been affected. In short, occasionally there may be the pathological condition optic neuritis without the symptom amaurosis attending or following it.

The other day, a necropsy was made on a patient who had had hemiplegia of the left side, and also had, Dr. Hughlings Jackson supposed, optic neuritis on but one side, the side opposite the lesion. This is the second case in which Dr. Hughlings Jackson has seen unioocular neuritis from intracranial tumour; in that case, also, the tumour was in the side opposite the neuritis (case reported, *Royal London Hospital Reports*, November, 1871, p. 180, microscopical examination of both eyes by Dr. Hermann Pagenstecher).

There is a woman, aged 42, who has double optic neuritis, and also loss of smell—possibly owing to olfactory neuritis. There is no affection of taste in the strict sense of the word taste; at any rate, she can recognize bitters and sweets (quinia and sugar were used.) The existence of anosmia, Dr. Hughlings Jackson believes, does not warrant the diagnosis of disease actually involving or directly squeezing the olfactory bulbs, any more than optic neuritis warrants the diagnosis of disease actually involving or directly squeezing the corpora quad-

rigemina, optic tracts, or optic nerves. Probably, in most cases, the disease which causes the anosmia is of the anterior lobe; as to the optic neuritis (with or without defect of sight), it is of no value whatever in localizing, any more than "cerebral" vomiting is. When the class saw her last, she was reading; and on trial, when helped by convex glasses to correct her presbyopia, she could read, although badly, No. 1½ of Snellen. Nevertheless, her optic discs are much swollen, the arteries are not traceable, the veins knuckle over the edge of the swelling, and there are effusions of blood. She has other symptoms, and these localize. She has occasionally convulsions, followed by hemiplegia, and nearly complete loss of speech. These symptoms point to disease of convulsions of the left cerebral hemisphere. Although there is no demonstrable evidence of syphilis, syphilitis of the brain is most likely to be the cause of the symptoms; and as her convulsive seizures have varied not only in degree, but in kind, probably there is more than one focus of disease in the brain.—*Brit. Med. Journ.*, July 20, 1872.

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Treatment of Strangulated Hernia by Puncture of the Intestine.—The very great importance to surgical practice which the introduction of any plan for the treatment of strangulated hernia implies, induces us to refer to a method suggested by Mr. Bryant in a clinical lecture delivered at Guy's Hospital in the month of February of this year.

Mr. Bryant gave the details of a case which occurred to him in 1871. It was that of an old man, aged 71, the subject of strangulated scrotal hernia, upon whom he had performed herniotomy, it being necessary to expose the bowel in order to return it. Owing to the restlessness of the patient, however, the gut again descended in a few hours, and all attempts to reduce it failed, until the large intestine was punctured in four or five places with a grooved needle, and a quantity of flatus (but no fecal matter) let out. The patient recovered without a single bad symptom. In his subsequent remarks upon this case, Mr. Bryant observed that

it proves clearly that puncturing the intestine freely may be resorted to with every prospect of success in some cases of hernia. He raised the question whether it is not possible to reduce some hernia without any operation at all, and he stated that he had made up his mind to try the practice in large scrotal and umbilical herniae, and thought favourably of its employment in all cases of acute internal strangulation due possibly to bands or twists.

Since the publication of this lecture the treatment of puncturing the bowel to remove strangulation has been followed in three cases (which are now well known), two of which have been published. The third occurred in the practice of Mr. Hulke, in the Middlesex Hospital, in the early part of May. The case was one of internal strangulation from a band, in which abdominal section was performed, and the distended small intestine punctured (ultimately laid open) before reduction of the bulging portions could be effected and the wound closed. This case, with Mr. Hulke's remarks, will shortly appear in our pages.

Of the two published ones, one was reported by Dr. Léon Labbé, of the Hôpital La Pitié. It was a strangulated inguinal hernia, of about eighteen hours' duration, in an old man, aged 70. Here, as the taxis failed, puncture with the aspirator was proposed, and a No. 2 needle introduced. In eight days the patient was well. The other case was one brought before the Académie de Médecine, on May 21, by M. Demarquay, full details of which will be found in the *American Journ. Med. Sci.* for July last, p. 267.—*Med. Times and Gaz.*, Aug. 3, 1872.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

The Current Materia Medica.—Dr. E. R. SQUIBB made some interesting remarks before the New York Academy of Medicine (June 20th, 1872), from which we extract the following:—

The various extracts of meat sold at the stores are of little value; there is not one of them, which is advertised, which

will bear out the remark of Dr. Christison, "they arrest waste, but do not keep up the supply." His impression is, that there is not as much against the use of solid food or aliment in disease as has been said against it. The stomach is not a chemical laboratory, "a kitchen for cooking food," as Abernethy wisely remarked. Food should not be subjected to the ordeal of chemists, as the fashion is.

Among the articles that have been introduced in the dietary department, and have taken a firm stand in the materia medica, is *pepsin*. Generally, however, patients have been in the habit of taking starch rather than pepsin. Once get up a reputation concerning a certain variety of this agent, the manufacturer has a good start for making money. Some specimens examined were good and others bad. The name of the maker is no guarantee, as it may be good at one time and poor at another. While the proprietor is looking after the money column, the manufacture is entrusted to another. The fresh supply of pigs' stomachs must come from the western pork-markets.

The pancreatic emulsions and preparations of bismuth and pepsin, so fashionable now, cannot be recommended: bismuth and pepsin cannot exist together. Those fashionable mixtures of beef and iron—as *Vinum cibi*, *Vinum cibi et ferri cum cinchona*, etc.—are gross frauds; only money is in them. Hardly any cod-liver oil will pass muster except it is tasteless; and his impression is that many of these preparations are not cod-liver oil at all, only oil made up for the market. Good oils should neither be too dark nor too light, but of a medium colour. The dark varieties are made of livers in a state of decomposition. There are good cod-liver oils in market which come from Norway and Newfoundland. The reason that the Norwegian oil is less rancid than others is, because it is never made at a less temperature than fifty degrees; consequently decomposition is avoided. Oil, when in use, should be kept in a cool place, as a refrigerator, and after each dose is given the glass should be thoroughly washed. Small pieces of ice put in the doses of dis-

agreeable substances, like cod-liver oil, render the agent almost tasteless. Those physicians who eschew the fashionable remedies take to the syrups, such as Aiken's syrup, etc. The lacto-phosphate of iron is based on fallacies like the others; but it is very taking, and is advocated by Horsford and others. Physicians are anxious to get solutions of phosphorus into the stomach, but before it gets there it becomes oxidized.

Another popular fallacy of the day is the use of sugar-coated pills or medical confectionery. Coroners have found these pills, after death, in the stomach and intestines, undissolved. Medicines should be given in such a shape that they will be quickly dissolved. It is not an easy matter to get the hard coat off the pills. Glycerin should be used in compounding pills, to render them soft. Pills made in this way are easily dissolved in the stomach. He has been astonished that Blancard's pill has been so useful as has been stated—it being covered with a metallic coat.

Medicines in capsules are not to be advocated—they being not easily dissolved.

The use of various forms of divided medicines, particularly "The Divided Medicine Co.'s" preparations, is another fallacy. It is nothing new, but an old way of preparing medicines. This way of dosing might be good if the physician would put the medicine up, but to purchase these preparations of companies is dangerous pharmacy. * * *

Condurango, which received its aid from the State Department at Washington, D. C., has pretty much gone out. That department deserves the reprobation of the physicians of this country. Reports have come back to the discredit of its use.

Nitrite of Amyl, introduced by the foreign physicians, and first written about by Dr. Richardson, of London, is a useful remedy. Cases of hemicrania, spasmodic asthma, etc., have been relieved by its inhalation. It is supposed to paralyze the nervous system of the arterioles; from sixty-five to seventy beats may be added in a few seconds by its use. The circula-

tion resumes its usual tone in a few minutes, and the effect of the remedy passes off.—*Medical Record*, Aug. 1, 1872.

Galvanic Treatment of Bed-sores and Indolent Ulcers.—Dr. WM. A. HAMMOND, of New York, recommends for indolent ulcers and bed-sores, the galvanic treatment as first suggested by Crussel, of St. Petersburgh. He says: “During the last six years I have employed it to a great extent in the treatment of bed-sores caused by diseases of the spinal cord, and with scarcely a failure; indeed, I may say, without any failure, except in two cases where deep sinuses had formed, which could not be reached by the apparatus. A thin silver plate—no thicker than a sheet of paper—is cut to the exact size and shape of the bed-sore; a zinc plate of about the same size is connected with the silver plate by fine silver or copper wire six or eight inches in length. The silver plate is then placed in immediate contact with the bed-sore, and the zinc plate on some part of the skin above, a piece of chamois-skin soaked in vinegar intervening. This must be kept moist, or there is little or no action of the battery. Within a few hours the effect is perceptible, and in a day or two the cure is complete in a great majority of cases. In a few instances a longer time is required. I have frequently seen bed-sores three or four inches in diameter, and half an inch deep, heal entirely over in forty-eight hours. Mr. SPENCER WELLS states that he has often witnessed large ulcers covered with granulations within twenty-four hours, and completely filled up and cicatrizations begun in forty-eight hours. During his recent visit to this country I informed him of my experience, and he reiterated his opinion that it was the best of all methods for treating ulcers of indolent character and bed-sores.”

Apparatus for Inhalation of Eucalyptus.—Dr. STOUT exhibited to the San Francisco Medical Society an apparatus for the inhalation of medicated vapours. The medicated liquid is kept boiling by a spirit lamp and the vapour conducted through a tube. He had used the eucalyptus in

this way, employing the tincture mixed in water. It was preferable to the common atomizer, because of the warm vapour, which is not only medicinal in itself but promotive of absorption. The eucalyptus he had found very beneficial in bronchial and pulmonic affections. Dr. STOUT also distributed some *cigarritos* made by inclosing the powder of the leaves in a roll of paper, which were puffed by the members with apparent satisfaction.

Dr. PIGNÉ-DUPUYTREN testified to the virtues of eucalyptus, which had been fully tested by himself and Dr. D'OLIVEIRA, in the French Hospital. It had been found highly serviceable in affections of the larynx and of mucous membranes in general; also as a tonic.—*Pacific Med. and Surg. Journ.*, Aug. 1872.

Successful Ligation of Right Carotid Artery for Aneurism.—Dr. PIGNÉ-DUPUYTREN exhibited to the San Francisco Medical Society a patient on whom he had performed this operation. The aneurism being on the right side and so near the innominate artery, it became a nice point to decide where the ligature should be placed, that it should not be too near the innominate to prevent the formation of a clot, or upon the diseased artery where a similar difficulty might arise. The ligature came away on the 17th day. In five months the tumour had entirely disappeared.—*Ibid.*

Total Rupture of the Intestines from injury without any external evidence.—A very interesting case of this is related (*Pacific Med. and Surg. Journ.*, Aug. 1872) by Dr. EDWIN BENTLY, Ass. Surg. U. S. A. A boy six years of age was accidentally crushed between the tail of a wagon and a board fence. He was taken up apparently fainting; stimulants were at once administered and he appeared to rally. The clothing being removed the body of the little fellow was carefully examined by an intelligent physician. No abrasion or bruise could be found over the entire surface, nowhere could tenderness be detected, and it was hoped the accident was not very serious. A suitable diet was directed,

and the stimulants continued; in expectation that with reaction from the shock and fright convalescence would ensue, or the severe features of the injury would become manifest. The first night was attended by a reasonable amount of repose, and on the following day, aside from the extreme paleness and anxious countenance, but little concern was apprehended. The second night was more restless, and constant nausea and frequent efforts at emesis occurred. The third morning it was noticed that the urine had been abundant, but no fecal discharge had taken place since the accident. Repeated cathartics were administered, but only to be returned like everything the stomach received. He was able to bear his weight upon his limbs and even to walk. It was thought evident that no bones were broken; the impression prevailed that if an evacuation could be obtained, the vomiting would be overcome, and little else would be needed; for the usual attendants of inflammation were not apparent, heat, pain, redness, and swelling were nowhere found. Purgatives in various forms were repeated. Yet nothing was retained; enemas were freely administered, to as little purpose. The third night the boy expired.

On post-mortem examination a few ounces of fluid was found in the cavity of the peritoneum; the serous coat of the small intestines was agglutinated together in patches; the ileum was ruptured in three places, and in one place, about ten inches from the ileo-caecal valve, was completely separated; the calibre of the intestine being torn asunder.

Summer Heat of 1872.—The records kept at the Pennsylvania Hospital show the temperature during June and July has been unprecedently high. The mean temperature for June was 76.62 degrees, within three-quarters of a degree of the highest ever known since the record has been kept, and for July 82.31, the highest ever recorded. Usually when June or July has been extremely warm, the preceding or succeeding month has been quite temperate, contrary to what has occurred the present summer. In this respect, as

well as in the unparalleled heat of July, the present summer has been the warmest on record in our vicinity.

During the month of July, 11.22 inches of rain fell, a quantity never exceeded but once previously, and then by only half an inch. Rain fell on eleven different days of the month, the heaviest fall being on the evening of July 4, and measuring 8.18 inches, while the average rain fall of the month during the past thirty-five years has been only 4.08 inches. During the first six months of the present year 18.24 inches of rain fell, making a total of 29.46 inches, against 28.26 inches during the first seven months of 1871.

Long Island College Hospital.—Dr. WM. WARREN GREENE has been appointed Professor of the Principles and Practice of Surgery and Clinical Surgery in the above school. Dr. G. enjoys a high reputation as a skilful surgeon.

FOREIGN INTELLIGENCE.

Hydrate of Chloral in Hooping-Cough.—Dr. KARL LORRY reports (*Deutsche Klinik*, 46, 1871) the results which he has obtained from the use of chloral hydrate in pertussis. He gives it in the following formula: Hydrate of chloral 5 parts, distilled water 150 parts, syrup of orange-peel 15 parts. The dose is from one to three teaspoonfuls, according to the age of the child. Generally, one teaspoonful is given in the morning, and one or two in the evening. The medicine is commenced as soon as the earliest characteristic symptoms appear, and is continued until the cough loses its catarrhal character. It is borne well by children, and produces no unpleasant consequences. It produces a marked reduction in the number and intensity, as well as in the duration, of the paroxysms.—*Brit. Med. Journ.*, July 20, 1872, from *Wiener Med. Wochenschr.*, June 15.

Nervous Sequelæ of Enteric Fever.—Dr. NOTHNAGEL has collected a number of notices of affections of the nervous system following enteric fever, and has published an interesting essay on the subject in the

Deutsches Archiv. für Klinische Medizin. In most cases where these disorders are met with, they consist of paralysis of motion and sensation; while, along with the diminished cutaneous sensibility, there may be severe pain. Paraplegia is the most common form; it is generally limited to the lower limbs, but sometimes one of the upper limbs is also affected, or there may be slight paralysis of both arms and legs. Much more rarely, one limb alone is affected, or one upper and one lower limb on opposite sides; and sometimes the paralysis is limited to parts supplied by special nerves or branches, especially the ulnar and peroneal nerves. Disturbance of the sensory function is more frequent than of the motor; assuming the form of hyperesthesia or of anesthesia, being generally limited in extent, and affecting the lower limbs, especially the feet. Neuralgia without paralysis, motor paralysis of the parts supplied by the cranial nerves, disorders of the optic nerve, and vaso-motor disturbances, are of rare occurrence. The actual pathological condition producing this disorder is not yet known; but Nothnagel is inclined to attribute the paralysis of enteric fever to the same cause as the paralysis following diphtheria, which, according to the researches of Oestel and Buhl, is dependent on diphtheritic infiltration (cell-proliferation) in the sheaths of the nerves and between the fasciculi, as well as among the ganglion-cells of the sensory nerves.—*Brit. Med. Journ.*, July 20, 1872.

Thoracentesis in Empyema.—M. SEDILLOT, in a discussion on this subject at the Academy of Medicine (June 25th, 1872), showed that the Hippocratic school had perfectly apprehended the indications in empyema, and made, in the therapeutics of this disease, the judicious application of most of the modes of treatment which are advanced, at the present day, as novelties.

He might have said the same of many other therapeutic and surgical measures which are often put forth as new, but which were well known to the fathers of medicine, and their value properly appreciated; but which have been overlooked

by their successors, and from time to time are revived by those who have more inventive talents than learning.

Treatment of Imperforate Anus.—Amongst the operations that may at any moment present themselves to the surgeon, that required for the relief of imperforate anus is one of the most delicate and important, and he should be prepared to meet any difficulties that may present themselves. "We too frequently neglect," says M. Verneuil, "to ask whether the newborn infant has evacuated the urine and meconium; and when it is ascertained that the anus is imperforate, much valuable time has been lost." Thus, he has himself been called upon to operate on the fourth day. He observes that the success of the operation has been made greater in recent times, when, instead of pushing a trocar at hazard in various directions, deliberate dissection has been made. This is particularly requisite where there is no projection of the rectum, or where the inferior extremity of the rectum is altogether absent. A convenient place should be selected, the infant on its belly, with the knees bent and thighs well separated. An incision should then be made from the easily found point of the coccyx, along the median raphé towards the scrotum or vulva. It is important to keep in the middle line, where we find always, as we are taught by embryogeny, in the absence of the rectum, a fibrous band which runs as far as to the membranous region or inferior third of the vagina. This is a valuable guide that must not be lost. When the incision made layer by layer is sufficiently deep, then may be perceived, on separating the cut edges of the wound well from each other, and directing a jet of cold water upon them, a small black point not larger than the head of a pin. This is the intestine, and if it be movable it should be drawn towards the skin. It is a fortunate circumstance when this can be done without opening it. More frequently it is only possible to seize the end of the intestine with the hook, and an incision is then made into it. The meconium then flows away, and begins at once to be a source

of trouble; its flow sometimes lasts for a considerable period. It must be watched with patience, and waited for till it has finished, in order to complete the operation, which consists in sewing the rectum securely to the skin, taking care that the opening is free, and that there are no chances of retraction or of infiltration. But it may also happen that a deep incision may be made into the perineum, and nothing may be found. The situation becomes a grave one, for it is necessary to continue the dissection into the true pelvis. The operation is difficult, and the guides to it obscure. Not unfrequently the absence of the rectum exists for a considerable portion of its extent. To keep straight in this course across the pelvis, it is important not to lose the walls, the curvature of the sacrum in particular, which is a valuable guide. It is, nevertheless, attended with much difficulty, and M. Verneuil has suggested a proceeding which materially facilitates it. It consists in giving a cut with the scissors on each side of the coccyx, which can then be drawn back, and at once affords greater space to work in. In one instance M. Verneuil found a cut of a quarter of an inch long on either side sufficient, but in others it is necessary to make the incisions nearly a quarter of an inch. He has thus succeeded in cases where otherwise the operation would have had to be given up, and some other attempted. Once formed, the retraction and contraction of the new anus should be prevented by directing the mother to introduce the point of the little finger into it several times a day. Most of the cases of imperforate anus prove fatal.—*The Practitioner*, Aug. 1872, from *Journal de Médecine et de Chirurgie*, tome xlii. part 2.

Operation for Harelip; the Cicatrical Contraction prevented by collodionized Strips of Wadding.—A case of harelip was reported in the *Gazette des Hôp.* (June 8), as illustrating M. Broca's employment of collodion. He practises the operation upon infants at the breast, securing union by silver threads, which he removes as soon as possible—the fifth, fourth, and often the third day. He does this not only from fear of threads cutting through

the tissues, but because suppurative inflammation set up around them may extend to the edges of the wound and disunite them; several examples of which he has seen. But a three days' cicatrix is not very solid, and cannot be relied on, seeing that the lips are exposed to much traction, especially during the cries of the child. This traction may be much diminished if, after the removal of the wires, a small portion of wadding is wetted with collodion, and spread (bringing the cheeks of the child together at the same time by bilateral pressure) out above the lip, stretching out on each side like a moustache. When the ether has evaporated, not only does this layer of collodion adhere closely, but it retracts, just as collodion does, without the wadding; and the lip is in this way supported and protected from all separation. These collodionized strips of wadding are also of great use in diminishing the size of suppurating wounds and their consecutive cicatrices by reason of the sliding or "mobilization" of the surrounding skin. M. Gosselin applies the same principle also in lesions of the lower eyelid, the cicatrices of which may give rise to ectropion, by exercising repeated pressure on the cheek from below upwards, pushing up the skin towards the eye. It acquires by this kind of shampooing a degree of mobility that may prevent the eversion of the eyelid.—*Med. Times and Gazette*, July 13, 1872.

Surgical Affections of Adolescents.—M. GOSSELIN, in a memoir read before the French Academy of Sciences, sought to show the influence exerted by the age of the patient in the choice of the means of treatment.

"For determining this choice," he says, "I offer the following formula for our guidance, viz.: 'The special spontaneous surgical affections of young persons have a tendency to persist, increase, or relapse, as long as the period of adolescence lasts; but these tendencies are lost as soon as adult age is reached.' Thus—1. In *In-growing nail* many are the remedies that have been recommended, and yet new ones are always being sought for, because, after

using those hitherto employed, relapse has ensued. Now, most frequently this depends upon the fact that the subject, being still young, retains the special pathological aptitude through which the disease was originally produced. For my part, I have never had occasion to observe relapse after the 25th year, and from this I conclude that, while we should take every care to prevent the return of the disease, we must not expect a definite cure as long as the patient has not reached his 23d or 24th year.

"2. In *valgus douloureux*, which I have also named *taralgia*, I have established that the disease depends on a special arthro-osteitis of the tarsus, developing itself as a consequence of the growth of this part of the skeleton; and that the chief indication consists in relieving the pain in walking and the concomitant contraction of the muscles of the leg, and thus preventing termination by muscular retraction, permanent valgus, and ankylosis. The best means for obtaining these results are, rest, *inamovible* apparatus, and sometimes tenotomy of the lateral peronei and electricity. But as long as the patient remains young, relapse is not always avoidable. When it does occur we must return to the employment of the same means, and not conclude too hastily that the disease is incurable; for by persevering in the treatment until the subject has attained the adult age we may prevent the consecutive deformity and infirmity which would ensue if the affection were left to itself.

"3. In *acute suppurating osteitis of the epiphysis*, when this has not been intense enough to call for primary amputation or to cause death, and when it has terminated by necrosis of long duration, I recommend that consecutive amputation should not be too readily determined upon; for in such cases I have seen the necrosis terminate and a definitive cure ensue, when the patient having reached his 25th or 26th year, has lost his predisposition to suppurative osteitis, which was a consequence of his age and an aberration of nutrition at the period of the juncture of the epiphyses.

"4. In *exostosis of the epiphyses*, or ex-

ostosis of development, my observations have taught me that the tumour ceases to grow and be painful when the subject has once passed adolescence; and, as its removal is a dangerous operation, I advise temporizing and leaving the affection to itself.

"5. In *subungual exostosis of the great-toe*—an affection too troublesome and too painful to allow of non-interference on the part of the surgeon—the relapses which follow their employment constitute the objection to most of the measures that have been proposed for its removal. But here, as in in-growing nail, I have found that, although relapse occurred while the patient still continued young, it ceased when once adult age had been reached.

"6. In *large fibrous naso-pharyngeal polypi*, the dimensions of which do not allow of their being treated even in a palliative manner without a preliminary operation affording access to their seat of implantation, this consideration regarding age is of primary consequence. I reject the excision of the upper jaw because it endangers life and leaves a mutilation of the face without assuring in an absolute manner against relapse. I prefer M. Nélaton's procedure—an aperture in the velum and arch of the palate—contenting myself with palliative operations by excision and cauterization, thus preserving the patient's life until the time when, being of adult age, he will in all probability have lost the disposition to reproduce the tumour."—*Med. Times and Gazette*, April 20, 1872. —*Med. News.*

Removal of Naso-Pharyngeal Tumour.

In order to gain access to the posterior nares and pharynx for the removal of tumours, Dr. von BRUNS, of Tübingen, operates in the following way. A horizontal incision is made along the upper lip (of a sufficient height to avoid wounding the mucous membrane) from a point a few millimetres below the right ala nasi to the level of the first molar tooth; a second incision is then made along the naso-frontal suture; and a third is curved obliquely down on the left side to the end of the lower incision. The base of the nasal spine is divided by a saw, and the

septum is cut through by bone-forceps; after which the bony parts are carefully sawn, and the right nasal bone is raised from its union with the maxillary. The whole nose can then be turned over on the right cheek, and replaced after the removal of the tumour. Of half only of the nose may be treated in the same way, by making the division between the nasal bones, and leaving the septum and the parts on the sound side uninjured. Dr. von Bruns has employed this method in three cases. In one of them, it was necessary to keep the nose displaced for three weeks; but at the end of that time, after the edges had been freshened, union rapidly took place. He says that this operation facilitates the removal of tumours and the arrest of hemorrhage; that it gives the surgeon the opportunity of watching the parts for some time, so as to perform any further operation that may be necessary; and that recovery takes place soon, and without any impairment of function. — *Brit. Med. Journ.*, June, 1872.

Fever and the Sewers.—[That sewer emanations are deleterious to health we are not prepared to deny; but we may state that we have some doubts as to their being the sole cause of the diseases ascribed to them, and it seems to us yet to be proved that such gases were the cause of the typhoid fever which afflicted the Prince of Wales some months since. The following statement seems to support these doubts.]

After all that has been said at the time of the Prince of Wales' illness, the public will be glad to learn, on authority, that the men employed in the sewers are not only not carried off by fever, but appear singularly free from the ravages of that disease. At the instigation of Dr. Brewster, the Metropolitan Board of Works ordered a return on the subject, which has just been issued, and is quite conclusive.

Out of 5 inspectors employed from 28 to 48 years, there has never been a case of fever. Out of 64 men employed in cleansing and flushing the northern sewers for periods varying up to 34 years, only 2 have had fever, and their cases were typhus. Out of 47 men engaged in

the sewer work in the southern sewers for periods varying from 1 to 24 years, there have only been 2 cases of fever, and these again typhus, and in one of these cases it is shown that the disease was contracted from the man's family. There are 86 penstock and flap-keepers who have been employed from 1 to 50 years. Of all these, only one has had any fever. He has been 16 years at work, and had typhoid in 1862. There are some curious notes about these men. One of them has been at this work 50 years, and has not had one day's illness during the time. One lived 25 years in the sluice house over the King's Scholars pond sewer, but never had any fever. Another lived for 14 years in Penstock House, over outfall sewer at Old Ford. Another lived 32 years in Great St. John's sluice house. Another lived for 35 years in a house over Duffield sluice, and enjoyed good health. Out of 54 men employed at the pumping stations, there has only been one case of fever (typhoid).

At Crossness, out of 54 men engaged during the last 6 years, there has not been one case of typhus or typhoid. There have been 8 cases of ague, but these are of course due to the low marshy district, and they seemed to have recovered rapidly. Out of 7 men employed in cleansing ventilators, oiling side entrances, gauges, &c., no case of fever has occurred, though one man has been at the work 23 years. Of 10 surveyors and chainmen in the engineer's office, not one has ever had typhoid fever, although they have been almost daily engaged in the sewers for periods of from 4 to 24 years.

These facts are very gratifying, and quite dispose of the allegation that the men in the sewers are decimated by fever. The statistics show, in fact, that fever is less prevalent amongst these men than the rest of the town population.—*Dublin Med. Press and Circular*, April 10, 1872.

Recent Epidemic of Variola at Leipsic.—Prof. WUNDERLICH states (*Archiv der Heilkunde*) that smallpox has prevailed more severely at Leipsic than in other places in Germany during the recent epidemic, and that in consequence of the

great neglect of vaccination and revaccination which has ensued upon the agitation of the so-called "nature-doctors." Until recently epidemics have been very few, and attended with a very slight mortality. During the years (1852-69) that he has been Director of the Municipal Hospital, there have been admitted 663 cases, furnishing only 29 deaths; and during the years 1868 (when the cases increased to 150) and 1869 (when they were 108) the deaths were only 10 and 3 respectively. The deaths almost exclusively occurred among the non-vaccinated; for while the general mortality from the disease was $4\frac{1}{2}$ per cent., that of the unvaccinated was 33 per cent. It was not until quite the end of 1870 that the epidemic seemed to be taking on large proportions, but from then to February, 1872, 1727 cases have been admitted; and although the number of admissions has gradually diminished since July, 1871, the epidemic can scarcely be regarded as terminated. Of course temporary hospitals (in the form chiefly of sheds) had to be provided, and among other contrivances the erection of a "station" for *suspected cases* proved of great value, as it had done formerly in cholera outbreaks. Many cases were sent to the hospital as smallpox, in which the diagnosis was not confirmed; others, which in the hospital were yet doubtful, were transferred here, so that they might be watched; and they were either discharged or returned to the hospital as the course of the disease indicated.

Of the 1727 patients 139 had not been vaccinated, 22 had already had variola, 1504 had been vaccinated, and of 62 no account could be got. In 79 revaccination had been performed, giving rise to pustules only in 18. The large proportion of the cases occurring in the vaccinated must excite surprise; but in point of fact a small proportion only of the population is unvaccinated; and infants, who constitute the great proportion of cases in the unvaccinated, are only brought to the hospital in direful emergencies. The present epidemic has been remarkable, not only for the number of cases, but for its great fatality. While during the last eighteen years the mortality from small-

pox has averaged $4\frac{1}{2}$ per cent., in this epidemic it has nearly reached (253 deaths in 1727 cases) 14.7 per cent.; and, making allowance for some of the deaths being due to other causes, the fatality has at least tripled itself. Of the 139 unvaccinated there died 99, or 71 per cent.; and of the 62 in whom it was doubtful whether vaccination had been performed, 32, or $51\frac{1}{2}$ per cent., died. Of the 22 persons who had smallpox for the second time, 6, or 27 per cent., died. Of the 1504 vaccinated, 116, or $7\frac{7}{10}$ per cent., died. None of the 18 successfully revaccinated died. As the epidemic diminished, the mortality became not only absolutely but *relatively* less. The observation applies during the whole eighteen years over which this account ranges, that the relative mortality is increased with the number of cases. Thus, with 168 in 1857, it was 5 per cent.; and in 1868, with 150 cases, $6\frac{1}{2}$ per cent.; while in the fifteen other years, during which the cases averaged 22, it was only $3\frac{1}{2}$ per cent. In the present epidemic it has reached 14.7 per cent. Sex exercised little influence on the mortality, but a very different account is to be given of age. Of 116 children under 15 years of age there died 78, or 68 per cent.; while of 1611 persons above that age there died 184, or $11\frac{1}{2}$ per cent. The contrast is still more remarkable in unvaccinated infants. Of 29 such under 1 year, 27 died, and of 31 under 2 years, 27 died. This influence diminishes in the third year, when of 15 unvaccinated, only 8 died; and of 23 between 4 and 8 years, only 7 died. The effect of vaccination in early life is strongly brought out by the fact that not a single vaccinated child of 8 years or under was brought to the hospital. The number of unvaccinated children of this age amounted to 100, and of these 69 died.

As still further illustrating the benefits of vaccination, it is stated, that, while, of 11 unvaccinated between 9 and 14 years, 4 died, none of the 20 vaccinated died. Between the years of 15 and 25 there were 11 unvaccinated with 4 deaths, and 801 vaccinated with 23 deaths. Of the 18 unvaccinated above 25 the whole died, while the mortality of the 671 vaccinated

amounted to 14 per cent.—*Med. Times and Gazette*, July 20, 1872.

Death from the Sting of a Bee.—On the 19th of July, a female, aged fifty-five, was stung by a bee behind the ear. Shortly afterwards she became unconscious, and died before the doctor who was sent for arrived. The brother of the deceased stated at the inquest that she was of a delicate and nervous constitution. In the autumn of 1870 she was stung by a bee, and the consequences were very peculiar. She became unconscious, and remained in that state for two hours. It is well known that many people endure far greater sufferings than others when stung by bees or other insects, and cases in which serious consequences have ensued are recorded. Beck, in his work on Medical Jurisprudence, quotes a case where a sting on the back of the finger was quickly followed by "vomiting, sweating, trembling, and great difficulty of breathing."

Dr. Tanner quotes a case from the *American Journal of the Medical Sciences*, of a man who suffered very seriously in the month of August, 1819, from the single sting of a bee, and who being stung a second time (on the temple) in the following year, died from the effects thereof within ten minutes. Two or three other cases of fatal result are quoted by the same author, but happily such an occurrence is exceedingly rare. The advice given by the coroner, Dr. Diplock, to "give stimulants freely" in such cases, is undoubtedly founded on sound principles, the immediate cause of death being apparently failure of the heart's action.—*Lancet*, July 27, 1872.

Coup de Soleil.—Several cases of sun-stroke were admitted last week into the London hospitals. The only fatal case, so far as we know, occurred at St. George's Hospital. One of the boys belonging to the *Goliath* training ship was struck down just after being reviewed by the Prince of Wales, in the Horticultural Gardens on Thursday week. He was brought to the hospital, and died in a few hours in spite of treatment; his temperature before death exceeded 109°. The necropsy showed nothing but very fluid blood and

a somewhat congested brain; the lungs and other organs were healthy. The absence of prodromata is remarkable in these cases. A strong-looking labourer of middle age was admitted also into St. George's Hospital on the 26th. He had been at work all the morning, and became suddenly unconscious just as he was going off to dinner; he declared that he had not been at all inconvenienced by the heat, had taken nothing to drink, and felt perfectly well till the moment of the attack. That "precaution is better than cure" is no doubt a stale and trite proverb; but in this, as in many other instances, it is as true as it is trite.—*Brit. Med. Journ.*, August 3, 1872.

Effects of the great Heat in England.—In England, as well as in this country, the heat of the summer has been unusually great, and there as here has resulted in increased mortality. In the *Lancet* of August 3d, it is stated that in London the general mortality has risen from 17 to 26 per 1000 in the last five weeks, the rate last week (26) being higher than in any previous week this year, a result almost exclusively due to the fatality of diarrhoea, which caused last week 394 deaths. The mortality from this cause was nearly all among children under five years of age, of whom 324 died in their first year. In the eighteen large towns the deaths registered from diarrhoea in the week ending 6th July were 113, in the next fortnight they were successively 226 and 370, and last week 604. In Leicester and Leeds the fatality is greater than in London, while in Hull it is equal, but in all the other towns considerably less fatal than in London. The Registrar-General refers in this connection to the "importance of pure water to children who drink freely in hot weather," and no doubt that is a most important matter; but it must be remembered that the mortality is to a large extent among infants, who are hardly likely to drink freely of water.

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